PRINTED: 05/27/2011

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | | RM APPROVED IB NO. 0938-0391 |
|--|----------------------|--------------------------------|------------------------|--|--|----------------------|---------------------------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MI | JLTIPLE C | ONSTRUCTION | (X3) DATE | |
| | OF CORRECTION | IDENTIFICATION NUMBER: 155214 | A. BUILDING B. WING | | 00 | COMPLETED 05/02/2011 | |
| NAME OF I | PROVIDER OR SUPPLIEI | R | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST ANTH | HONY HOME | | | 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTIO | N. | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PERCEDED BY FULL | PREFIX | | (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP | BE | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | TOTAL | DATE |
| F0000 | | | | | | | |
| | This visit was fo | or a Recertification and | F0 | 000 | St. Anthony Home ("the p | rovider") | |
| | State Licensure | Survey. | | | submits this Plan of Corre ("POC") in accordance with | :h | |
| | Survey dates: A | pril 25, 26, 27, 28, and | | | specific regulatory require | | |
| | May 2, 2011 | . , , , , | | | admission of any alleged | | |
| | | | | | deficiency cited. The Prov | | |
| | Facility number: | 000120 | | | submits this POC with the intention that it be inadmis | | |
| | Provider number | r: 155214 | | | any third party in any civil | • | |
| | AIM number: | 100274780 | | | criminal action against the | | |
| | | | | | Provider or any employee | - | |
| | Survey team: | | | | officer, director, or shareh the Provider. The Provider | | |
| | Marcia Mital, R | N, TC | | | hereby reserves the right | | |
| | Sheila Sizemore | | | | challenge the findings of t | | |
| | Kelly Sizemore, | | | | survey if at any time the P | | |
| | (April 25, 26, 27 | | | | determines that the disput | | |
| | Regina Sanders, | | | | findings: (1) are relied upon adversely influence or ser | | |
| | (April 25 and 26 | | | | basis, in any way, for the | ve as a | |
| | (11)111 20 4114 20 | ,, = 0 1 1) | | | selection and / or imposition | on of | |
| | Census bed type | | | | future remedies, or for any | | |
| | SNF: 30 | • | | | increase in future remedie | • | |
| | NF: 111 | | | | whether such remedies ar imposed by the Centers for | | |
| | SNF/NF: 30 | | | | Medicare and Medicaid S | | |
| | NCC: 12 | | | | ("CMS"), the state of India | na or | |
| | Total: 183 | | | | any other entity; or (2) to s | | |
| | 10tal. 183 | | | | any way, to facilitate or pr | | |
| | Commanda | | | | action by any third party a the Provider. Any change | | |
| | Census Payor ty | pe: | ı | | Ally change | 0.10 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Medicare:

Medicaid:

Sample: 26

Other:

Total:

30

103

50

183

Event ID:

HTE311

Facility ID:

000120

Provider policy or procedures

subsequent remedial measures

as that concept is employed in Rule 407 of the Federal Rules of

inadmissible in any proceeding on

should be considered to be

Evidence and should be

that basis.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| l | IT OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | | ESURVEY PLETED 2011 |
|--------------------------|-------------------------------------|---|--|---|-------|----------------------------|
| | PROVIDER OR SUPPLIEF | 2 | 203 FR | ADDRESS, CITY, STATE, ZIP COD ANCISCAN DRIVE N POINT, IN46307 | E | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | Supplemental sa NCC Sample: 1 | | | | | |
| | | es also reflect state accordance with 410 IAC | | | | |
| | Quality review c Cathy Emswiller | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214 | | | (X2) MUL A. BUILD B. WING | | OO | (X3) DATE S COMPL 05/02/2 | ETED |
|---|--|--|---------------------------------|---------|---|---------------------------------|----------------------|
| | PROVIDER OR SUPPLIER | | | 203 FRA | DDRESS, CITY, STATE, ZIP CODE NCISCAN DRIVE POINT, IN46307 | | |
| | SUMMARY S (EACH DEFICIENT REGULATORY OR A facility must immore sident; consult wand if known, notification representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuc conditions or clinical ter treatment significant in he psychosocial statuc conditions or clinical ter treatment significant in adverse consequency form of treatment facility as specified. The facility must a resident and, if known representative or in when there is a change in resided State law or regular paragraph (b)(1) or side side in the summary of the summary or in the summar | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) nediately inform the vith the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening all complications); a need to nificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the own, the resident's legal interested family member ange in room or roommate accified in §483.15(e)(2); or activities in the strength of the strength o | PI | 203 FRA | NCISCAN DRIVE | E | (X5) COMPLETION DATE |
| | update the addres resident's legal repfamily member. Based on reinterview, 1 | ecord review and the facility failed ident's physician | F01: | 57 | 1.1 Regarding resident #13 Unit Nurse Manager / designimmediately assessed reside 4/26/11 with no adverse reac noted. Unit Nurse Manager notified physician and family the occurrence on 4/26/11. 1.2 Unit Nurse Managers / designees reviewed current 24-hour reports related to | ee nt on tions | 06/01/2011 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | IULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|--|----------------------|--|-------------|--|---|------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 155214 | - 1 | LDING | 00 | COMPL 05/02/2 | |
| | | 100211 | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 00,02,2 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 1 | ANCISCAN DRIVE | | |
| ST ANTH | HONY HOME | | | | N POINT, IN46307 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| | constipatio | n for 1 of 26 | | | physician notification on 4/26 with no other deficiencies no | | |
| | _ | eviewed for | | | at that time. 1.3 Director of Staff | icu | |
| | physician r | notification in a | | | Development / designee will re-inservice licensed staff | | |
| | total sampl | e of 26. | | | regarding physician notificati | on by | |
| | (Resident # | | | | 5/30/11. Unit Nurse Manage designees will review five (5) | | |
| | | 133) | | | 24-hours reports per unit we | ekly | |
| | | | | | to ensure physician notification completed for six (6) months | | |
| | Findings in | iclude: | | | beginning the week of 5/23/1 | 1. | |
| | | | | | 1.4 The DON will report au findings to the Continuous Q | | |
| | 1. Resident | #135's record | | | Improvement (CQI) Committ | ee | |
| | was review | red on 4/26/11 at | | | monthly for six (6) months with the next meeting to be held | | |
| | 2:30 p.m. | Resident #135's | | 5/31/11. The CQI Committee will monitor data presented for any | | ny | |
| | diagnoses i | ncluded, but | | | trends, and determine if furth monitoring is necessary for | ier | |
| | were not lin | mited to, | | | compliance. 1.5 Systemic changes will | be | |
| | hypertensic | on, stroke, and | | | completed by 6/1/11. | | |
| | osteoporos | | | | | | |
| | | 13. | | | | | |
| | A care plan | a, dated 6/21/10 | | | | | |
| | • | 11/11, indicated | | | | | |
| | _ | • | | | | | |
| | "At risk for | | | | | | |
| | constipatio | nStool softener | | | | | |
| | per MD ord | der. Monitor | | | | | |
| | 1 | of stool. Laxative | | | | | |
| | | or stoor. Danative | | | | | |
| | | | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214 | (X2) MULTII A. BUILDIN B. WING | | NSTRUCTION 00 | (X3) DATE S COMPL 05/02/2 | ETED |
|--------------------------|--|---|--------------------------------|--------|--|---------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 20 |)3 FRA | DDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE I POINT, IN46307 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREI TA | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | PRN (as ne | eeded) per MD | | | | | |
| | order. Incre | ease fluids to | | | | | |
| | resident's to | olerance" | | | | | |
| | On 4/25/11 CNA #3 rethat resider was "real rethat resider was "real rethat resider movement form, dated 4/26/11, incresident hat 3/29/11, 4/4/6/11, 4/16 and 4/25/11 The resider dated 4/25/ | at 2:00 p.m., ported to LPN #6 nt #135's stool eal hard." nt's bowel monitoring 13/26/11 through dicated the d hard stools on 1/11, 4/2/11, 0/11, 4/16/11, 1. nt's nurses' notes, | | | | | |
| | the residen | t had hard stools, | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | INSTRUCTION 00 | (X3) DATE S COMPL | |
|-----------|---------------------------------|--|-------------------|------------|---|----------------------|------------|
| THEFTERN | or conduction | 155214 | A. BUII B. WIN | | | 05/02/2 | |
| NAME OF P | ROVIDER OR SUPPLIER | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | IONY HOME | | | | ANCISCAN DRIVE N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | V1 OIIV1, IIV 4 0307 | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | or of the ph | ysician being | | | | | |
| | notified of | the resident's | | | | | |
| | hard stools. | | | | | | |
| | | | | | | | |
| | During an i | interview on | | | | | |
| | 4/26/11 at 2 | 2:37 p.m., the 3A | | | | | |
| | and 3C Hal | ls Unit Manager, | | | | | |
| | indicated th | ne resident had | | | | | |
| | | g hard stools and | | | | | |
| | · · | to see about | | | | | |
| | | | | | | | |
| | | resident a stool | | | | | |
| | softener. S | he indicated the | | | | | |
| | nurse shoul | ld have done | | | | | |
| | something | yesterday when | | | | | |
| | the CNA re | • | | | | | |
| | | s having hard | | | | | |
| | | | | | | | |
| | | e indicated she | | | | | |
| | _ | the resident's | | | | | |
| | physician. | | | | | | |
| | | | | | | | |
| | During an i | nterview on | | | | | |
| | 4/26/11 at 3 | 3:20 p.m., LPN | | | | | |
| | | _ | | _ | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|--|--|---|------------------------|--|----------------------------------|
| | | 155214 | A. BUILDING B. WING | | 05/02/2011 |
| | PROVIDER OR SUPPLIER | | 203 FF | ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DRIVE VN POINT, IN46307 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | #9 indicate | d she had gotten | | | |
| | an order for | r lactulose (a | | | |
| | medication | for | | | |
| | constipation | n) for the | | | |
| | resident. | | | | |
| | 3.1-5(a)(2) 3.1-5(a)(3) | | | | |
| F0253 SS=E | maintenance servial a sanitary, orderly, Based on observation facility failed to a comfortable interaccumulation of a rubber caulking of shower rooms on the potential to a reside on 2C. The ensure vent cover rooms were clear to 10 of 16 rooms with rust stains or | a black substance on the of the floor in 1 of 6 of 1 of 3 floors. This had ffect 19 residents who are facility also failed to are inside the residents' and maintained, related as observed on the 3D unit on the vent. (Rooms 383, 92, 393, 394, 395, 396, | F0253 | 1.1 The black substance on rubber surrounding the tile flooring in the 2C shower rowas removed on 4/26/11. 1.2 All shower rooms were checked for any black substante on the rubber areas surround the tile flooring by 4/27/11 wany deficiencies noted correat that time. 1.3 The Director of Staff Development / designee will re-inservice staff regarding maintaining a sanitary and comfortable interior related to rubber areas surrounding the flooring of shower rooms by 5/30/11. The Director of Housekeeping / designee will | om ance ding ith cted o e tile |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HTE311 Facility ID:

000120

If continuation sheet

Page 7 of 43

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | VEY |
|--|---|------------------------------|---|--------|--|-----------|-----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COM | | | COMPLETI | ED |
| | | 155214 | B. WIN | | | 05/02/201 | 1 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | | | |
| OT ANITI | IONIVITIONE | | | I | ANCISCAN DRIVE | | |
| STANTE | IONY HOME | | | CROW | N POINT, IN46307 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re C | OMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | | | | audit shower rooms three (3 |) | |
| | During the envir | onmental tour of the | | | times per week beginning we | eek | |
| | · · | | | | of 5/23/11 for six (6) months | for | |
| | 1 * | /11 at 10:55 a.m. through | | | cleanliness of rubber areas | | |
| | 12:30 p.m., with | | | | surrounding the tile flooring. | | |
| | Maintenance, the | e Director of | | | 1.4 The Director of | | |
| | Housekeeping, a | nd the Administrator, the | | | Housekeeping will report au | | |
| | following was ob | · | | | findings to the Continuous Q | , , | |
| | Tollowing was of | oserved. | | | Improvement (CQI) Committ | | |
| | 1) 771 | | | | monthly for six (6) months w | itn | |
| | l ' | accumulation of a black | | | the next meeting to be held | ا النبد | |
| | substance located | d on the rubber that goes | | | 5/31/11. The CQI Committe | I . | |
| | around the tile flo | oor in the shower room | | | monitor data presented for a | | |
| | on 2C. The black | k substance came off of | | | trends, and determine if furth monitoring is necessary for | iei | |
| | | | | | compliance. | | |
| | _ | wiping it with a paper | | | 1.5 Systemic changes will b | _ | |
| | towel. | | | | completed by 6/1/11. | ~ | |
| | | | | | Sempleted by early in | | |
| | Review of the fa | cility roster, provided by | | | 2.1 Rust spots on vent cove | rs in | |
| | the facility on 4/2 | 25/11, indicated there | | | resident rooms 383, 384, 39 | | |
| | 1 | s who reside on 2C. | | | 391, 392, 393, 394, 395, 396 | and | |
| | were 17 resident. | s who reside on 2C. | | | 399 were sandblasted and | | |
| | | | | | repainted on 4/27/11. | | |
| | _ | iew at the time of the | | | 2.2 Vent covers in all other | | |
| | observation, the | Director of Housekeeping | | | resident rooms were checke | I . | |
| | indicated the rub | ber was old. She | | | rust spots by 4/30/11 with ar | | |
| | indicated the nig | ht technician scrubbed | | | deficiencies noted corrected | at | |
| | · · | last week. She indicated | | | that time. | | |
| | | | | | 2.3 The Director of Staff | | |
| | | was used by all the | | | Development / designee will re-inservice staff regarding | | |
| | residents on the 2 | 2C unit. | | | maintaining a sanitary and | | |
| | | | | | comfortable interior related t | , | |
| | 2) During the ob | oservation of the 3D hall, | | | room vent covers by 5/30/11 | | |
| | | pots all over the vent | | | The Director of Maintenance | | |
| | 1 | | | | designee will audit five (5) | | |
| | covers located inside the door of rooms | | | | resident room vent covers pe | er | |
| | 383, 384, 390, 391, 392, 393, 394, 395, | | | | unit weekly beginning week | | |
| | 396, and 399. | | | | 5/23/11 for six (6) months for | . | |
| | | | | | presence of rust spots. | | |
| | During an intervi | iew at the time of the | | | 2.4 The Director of Mainten | ance | |
| | - | | | | | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155214 05/02/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DRIVE ST ANTHONY HOME **CROWN POINT, IN46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE will report audit findings to the observation, the Administrator Continuous Quality Improvement acknowledged the rust on the vent covers. (CQI) Committee monthly for six (6) months with the next meeting 3.1-19(f)to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 2.5 Systemic changes will be completed by 6/1/11. F0282 The services provided or arranged by the facility must be provided by qualified persons SS=E in accordance with each resident's written plan of care. Regarding resident #135, 06/01/2011 F0282 Based on observation, Unit Nurse Manager / designee record review, and immediately assessed resident on 4/26/11 with no adverse reactions interview, the facility failed noted. Unit Nurse Manager notified physician and family of to ensure physician's orders the occurrence on 4/26/11. 1.2 Unit Nurse Managers / and resident's plans of care designees reviewed current physician orders and MARs of were followed related to residents receiving eye drops on 4/26/11 to ensure physician medications for 5 of 26 orders followed with no other deficiencies noted. residents reviewed for 1.3 Director of Staff following physician's orders Development / designee will re-inservice licensed staff and and plans of care, in a total QMAs regarding following physician orders related to eye sample of 26. (Residents drop medication administration by 5/30/11. Unit Nurse Managers / #26, #120, #135, #162 and designees will review five (5) resident MARs with eye drops #163) weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | (X3) DATE SURVEY |
|--|----------------------|------------------------------|--|---|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED |
| | | 155214 | B. WIN | | | 05/02/2011 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | ļ. |
| NAME OF I | PROVIDER OR SUPPLIER | <u>.</u> | | 203 FR | ANCISCAN DRIVE | |
| ST ANTH | IONY HOME | | | CROW | N POINT, IN46307 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | · | DATE |
| Findings include: | | | | 1.4 The DON will report au findings to the Continuous Q | | |
| | _ | | | | Improvement (CQI) Committ | • |
| | | | | | monthly for six (6) months w | ith |
| | 1. Resident | #135's record | | | the next meeting to be held 5/31/11. The CQI Committee | e will |
| | was review | red on 4/26/11 at | | | monitor data presented for a | ny |
| | 2:30 p.m. | Resident #135's | | | trends, and determine if furth monitoring is necessary for | ner |
| | • | ncluded, but | | | compliance. 1.5 Systemic changes will | be |
| | were not li | ŕ | | | completed by 6/1/11. | |
| | | on, stroke, and | | | 2.1 Regarding resident #120 | • |
| | | | | | Unit Nurse Manager / desigr immediately assessed reside | I |
| | osteoporos | 1S. | | | 4/27/11 with no adverse read | . |
| | | | | | noted. Unit Nurse Manager | |
| | A phygicia | n's order detad | | | notified physician and family the occurrence on 4/27/11. | of |
| | 1 2 | n's order, dated | | | 2.2 Unit Nurse Managers / | |
| | 4/9/11, ind: | icated "obtain | | | designees reviewed current | |
| | cultureGa | aramycin | | | physician orders and MARs residents receiving blood | of |
| | | • | | | pressure medication on 4/27 | /11 to |
| | (antibiotic | eye medication) | | | ensure physician orders follo | I |
| | opth (eye) | gtts (drops) ii | | | with no other deficiencies no 2.3 Director of Staff | ted. |
| | (two) gtts e | each eye bid | | | Development / designee will | . |
| | ` | y) x (times) 7 | | | re-inservice licensed staff an QMAs regarding following | la |
| | ` | <i>J</i> / () | | | physician orders related to b | lood |
| | days." | | | | pressure medication administration by 5/30/11. U | Init |
| | | | | | Nurse Managers / designees | I |
| | A laborator | ry test datad | | | review five (5) resident MAR | s |
| | | y test, dated | | | with blood pressure medicati | ion |
| | 4/13/11, ind | dicated the eye | | | weekly per unit to ensure physician order followed | |
| | culture had | very few MRSA | | | beginning week of 5/23/11 fo | or six |
| | Cultuic Hau | very new mixom | | | (6) months. | |
| | | | | | 2.4 The DON will report au | ıdit |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION 00 | | | (X3) DATE SURVEY COMPLETED | |
|--|----------------------------|--|-----------------------|-------------|--|-----------------|
| Tan Di Di III | 2. 2014.011 | 155214 | A. BUILDIN B. WING | NG | | 05/02/2011 |
| | | | | TREET AI | DDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | NCISCAN DRIVE | |
| | IONY HOME | | c | CROWN | POINT, IN46307 | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | II | - 1 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | · · | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | EFIX AG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE |
| | (methicillin | n resistant) | | | findings to the Continuous Quantum (CQI) Committee | • 1 |
| | staphylocci | • | | | monthly for six (6) months wi | |
| | Stupiny loce | us aurcus. | | | the next meeting to be held 5/31/11. The CQI Committee | a will |
| | | | | | monitor data presented for a | |
| | A care plan | i, dated 4/11/11, | | | trends, and determine if furth | er |
| | indicated " | (Resident #135's | | | monitoring is necessary for compliance. | |
| | | s/s (signs and | | | 2.5 Systemic changes will | be |
| | | ` • | | | completed by 6/1/11. | |
| | , | of possible eye | | | 3.1 Regarding resident #162 | |
| | infection] | Meds | | | Nurse Practitioner was alread notified on 4/8/11 of the | ay |
| | (medication | ns) as ordered" | | | occurrence on 4/7/11 and 4/8 | 3/11 |
| | | , | | | by LPN #2. 3.2 Unit Nurse Managers / | |
| | | C. 11 / 1 | | | designees reviewed current | |
| | A MAR (M | | | | physician orders and MARs or residents receiving nasal spr | |
| | Administra | tion Record), | | | on 4/27/11 to ensure physicia | an |
| | dated 4/11. | indicated the | | | orders followed with no other deficiencies noted. | |
| | resident rec | | | | 3.3 Director of Staff | |
| | | | | | Development / designee will re-inservice licensed staff an | d |
| | | eye drops once | | | QMAs regarding following | <u> </u> |
| | on $4/10$, tw | rice a day on | | | physician orders related to no spray administration by 5/30/ | |
| | 4/11, 4/12, | 4/13, 4/14, 4/15, | | | Unit Nurse Managers / desig | nees |
| | | 1. The resident | | | will review five (5) resident M with nasal spray weekly per u | |
| | | | | | to ensure physician order | |
| | should have | | | | followed beginning week of 5/23/11 for six (6) months. | |
| | another dos | se of the | | | 3.4 The DON will report au | |
| | Garamycin | eye drops on | | | findings to the Continuous Quantum Improvement (CQI) Committee | • 1 |
| | 4/17/11. | - | | | monthly for six (6) months wi | |
| | ., . , , | | | | the next meeting to be held 5/31/11. The CQI Committee | e will |
| FORM CMS-2 | 567(02-99) Previous Versio | ons Obsolete Event ID: H | TE311 | Facility II | <u> </u> | |

| SELLIDAN OS/02/2011 | | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION 00 | (X3) DATE S COMPL | |
|--|------------|--|--|---------|------------------------|--|--|------|
| STREET ADDRESS. CITY. STATE. ZIPCODE 203 FRANCISCAN DRIVE CROWN POINT. IN46307 | THILD TEAM | or condition | | - 1 | | | | |
| PRETIX TAG REGULATORY OR I SC IDENTIFYING INFORMATION) During an interview on 4/26/11 at 2:42 p.m., LPN #7 indicated the resident had not received the eye drops as ordered. During an interview on 4/26/11 at 2:57 p.m., LPN #9 indicated the resident should have received another dose of the eye drops. 2. Resident #120's record was reviewed on 4/27/11 at 9:40 a.m. Resident #120's diagnoses included, but were not limited to, hypertension, stroke, and dementia. PRETIX TAG REGULATORY OR I SC IDENTIFYING INFORMATION) #0 indicated the resident should have received another dose of the eye drops. PRETIX TAG **TAG **TAG **COMPLETIX TAG **TAG **TAG | ST ANTH | IONY HOME | | p. wii. | STREET A 203 FRA CROWN | ANCISCAN DRIVE N POINT, IN46307 | | (X5) |
| During an interview on 4/26/11 at 2:42 p.m., LPN #7 indicated the resident had not received the eye drops as ordered. During an interview on 4/26/11 at 2:57 p.m., LPN #9 indicated the resident should have received another dose of the eye drops. 2. Resident #120's record was reviewed on 4/27/11 at 9:40 a.m. Resident #120's diagnoses included, but were not limited to, hypertension, stroke, and dementia. t.1-A Regarding resident #163, on 4/28/11 resident was at the hospital. 4.1-A Regarding resident #163, on 4/28/11 resident was at the hospital. 4.2-A Unit Nurse Managers / designees reviewed current diabetic flow sheets related to blood glucose monitoring and sliding scales on 4/28/11 with no other deficiencies noted. 4.3-A Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding facility medication policy and procedure related to blood glucose monitoring and sliding scales by 5/30/11. DN reviewed current practices with Pharmacy, with Pharmacy to supply blood glucose monitoring records in chronological time order beginning 6/11. Link Iurse Managers / designees will review five (5) resident diabetic flow sheets of those receiving blood glucose monitoring and sliding scale sop five (5) resident diabetic flow sheets relose receiving blood glucose monitoring and sliding scale sop five (5) resident diabetic flow sheets relose receiving blood glucose monitoring and sliding scale sop five (5) resident diabetic flow sheets relose receiving blood glucose monitoring and sliding scale weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-A The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee | | ` | | | I | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΤE | |
| the next meeting to be held | | 4/26/11 at 2 #7 indicate had not rec drops as or During an id 4/26/11 at 2 #9 indicate should have another dos drops. 2. Residen was review 9:40 a.m. Idiagnoses if were not line hypertension. | 2:42 p.m., LPN d the resident eived the eye dered. interview on 2:57 p.m., LPN d the resident e received se of the eye t #120's record red on 4/27/11 at Resident #120's ncluded, but mited to, | | | trends, and determine if furth monitoring is necessary for compliance. 3.5 Systemic changes will completed by 6/1/11. 4.1-A Regarding resident #1 on 4/28/11 resident was at thospital. 4.2-A Unit Nurse Managers designees reviewed current diabetic flow sheets related the blood glucose monitoring and sliding scales on 4/28/11 with other deficiencies noted. 4.3-A Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding facility medication policy and procedure related to blood glucose monitoring and sliding scales 5/30/11. DON reviewed currestrated to blood glucose monitoring records in chronological time order beginning 6/1/11. Unit Nurse Managers / designees will refive (5) resident diabetic flow sheets of those receiving blog glucose monitoring and sliding scale weekly per unit to ensurphysician order followed beginning week of 5/23/11 for (6) months. 4.4-A The DON will report a findings to the Continuous Q Improvement (CQI) Committing monthly for six (6) months will resident will reside the continuous Q Improvement (CQI) Committing monthly for six (6) months will resident will reside the continuous Q Improvement (CQI) Committing monthly for six (6) months will resident will resident will resident will resident will resident will report a findings to the Continuous Q Improvement (CQI) Committing monthly for six (6) months will resident will | be 163, ne 163 | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|--|---|---------------|---|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLETED | |
| | | 155214 | B. WIN | | 05/02/2011 | | |
| ST ANTH | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX TAG | · · | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION DATE | |
| ino | The physic recapitulati | | | 1110 | 5/31/11. The CQI Committee monitor data presented for a trends, and determine if furth monitoring is necessary for compliance. | e will ny | |
| ı | | ` | | | 4.5-A Systemic changes will | be | |
| | pressure m | edication) 0.3 | | | completed by 6/1/11. | | |
| | milligram/2 apply to sk Sunday. The resider 4/11, indicated the clonidinal applied becavailable. The indicated the received the on 4/24/11 Observation clonidine, of the clo | 24 hour patch, in every week on ht's MAR, dated ated on 4/17/11 he patch was not cause it was not was it was not when the MAR he resident had e clonidine patch as ordered. In of the box of on 4/27/11 at indicated the had sent 4 | | | 4.1-B Regarding resident #1 on 4/28/11 resident was at the hospital. 4.2-B Unit Nurse Managers designees reviewed physicial orders and TARs for accurace related to Lotrimin Cream on 4/28/11 with no other deficient noted. 4.3-B Director of Staff Development / designee will re-inservice licensed staff an QMAs regarding facility treat application procedure by 5/3 Unit Nurse Managers / desig will review five (5) residents we treatment orders weekly per to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-B The DON will report at findings to the Continuous Q Improvement (CQI) Committed findings to the Continuous Q Improvement (CQI) Committed findings to the Continuous Q Improvement (CQI) Committed for a trends, and determine if furth monitoring is necessary for compliance. 4.5-B Systemic changes will completed by 6/1/11. | d ment 0/11. nees with unit udit uality ee th e will ny eer | |
| | | | | | 5.1 Regarding resident #26, | Unit | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|------------|------------|---|--|
| AND I LAN OF CO. | KKLCTION | 155214 | A. BUII | | 00 | 05/02/2011 |
| ST ANTHONY (X4) ID PREFIX TAG F | SUMMARY ST (EACH DEFICIENC REGULATORY OR I | TATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) THE WERE 3 | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Nurse Manager assessed | (X5) |
| Du ab #9 Ur res the be pa | tches left uring an invove date of the 3A anit Managaident had be patch of cause the tch missi | in the box. nterview at the and time, LPN and 3C Halls ger, indicated the d not received | | | resident on 4/26/11 with no adverse reactions noted. Un Nurse Manager notified phys and family of the occurrence 4/26/11. 5.2 Unit Nurse Managers / designees reviewed current physician orders and MARs or residents receiving eye drops 4/26/11 to ensure physician orders followed with no other deficiencies noted. 5.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to eydrop medication administration 5/30/11. Unit Nurse Manage designees will review five (5) resident MARs with eye drop weekly per unit to ensure physician order followed beginning week of 5/23/11 for (6) months. 5.4 The DON will report autindings to the Continuous Qualimprovement (CQI) Committed monthly for six (6) months with enext meeting to be held 5/31/11. The CQI Committed monitor data presented for an trends, and determine if furth monitoring is necessary for compliance. 5.5 Systemic changes will I completed by 6/1/11. | ician on of s on d ye on by rs / s r six dit uality ee th e will ny er |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING B. WING (X3) DATE SU COMPLE 05/02/20 | | | | | |
|---|--|--|------------------|---------------------|--|----|----------------------------|
| NAME OF I | PROVIDER OR SUPPLIER | <u> </u> | <i>p.</i> ,,,,,, | STREET A | ANCISCAN DRIVE | | |
| ST ANTH | HONY HOME | | | 1 | N POINT, IN46307 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | to congestive heart failure and macular degeneration. | | | | | | |
| | A physician's order, dated 3/26/11, indicated "Nasonex (nasal congestion) nasal spray, 1 spray each nostril daily." | | | | | | |
| | An April 2011, MAR indicated the nose spray was not administered on 4/7 and 4/8/11, as indicated by circled nursing | | | | | | |
| | initials. The back of the MAR indicated "4/7/119am not available told (nurse's name) ordered. Pharm (pharmacy) sent | | | | | | |
| | 3/264/8/11 una from pharmacy.' | able to find 9a ordered | | | | | |
| | A nurses' note, dated 4/8/11, indicated "Nasonex spray ordered from Pharmacy. No adverse reactions observed r/t (related to) not received nasal spray. NP (nurse | | | | | | |
| | practitioner) here | e and notified." | | | | | |
| | a.m.,LPN #10, t indicated she had | iew on 4/28/11 at 10:05 he 3B Hall Unit Manager d thought LPN #2 had spray and administered it. | | | | | |
| | a.m., LPN #2 inc the resident's nas | iew on 4/28/11 at 10:15 dicated she could not find sal spray. LPN #2 I not administer the | | | | | |
| | resident's nasal s | pray on 4/8/11 as have delivered the nasal | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | | |
|---|----------------------|------------------------------|------------|-------------|---|---------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 155214 | B. WIN | | | 05/02/2 | 011 |
| NAME OF I | DDOWNED OD CUDDI IED | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 203 FR | ANCISCAN DRIVE | | |
| | HONY HOME | | | CROW | N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | <u> </u> | LSC IDENTIFYING INFORMATION) | + - | TAG | | | DATE |
| | | 3's record was reviewed | F0 | 282 | 1.1 Regarding resident #13 Unit Nurse Manager / desigr | | 06/01/2011 |
| | on 4/28/11 at 10 | a.m. Resident #163's | | | immediately assessed reside | | |
| | diagnoses include | ed, but were not limited | | | 4/26/11 with no adverse read | | |
| | to, stroke, insulir | dependent diabetes | | | noted. Unit Nurse Manager | | |
| | mellitus, and hyp | pertension. | | | notified physician and family | of | |
| | | | | | the occurrence on 4/26/11. | | |
| | A. A Physician's | s Recapitulation Orders, | | | 1.2 Unit Nurse Managers / designees reviewed current | | |
| | 1 | licated "blood glucose | | | physician orders and MARs | of | |
| | | and record 4 times daily | | | residents receiving eye drop | | |
| | 1 | og (insulin) 100 u | | | 4/26/11 to ensure physician | | |
| | 1 | iter) vial per sliding scale | | | orders followed with no other | r | |
| | | sed on blood sugar | | | deficiencies noted. | | |
| | 1 ` | · · | | | 1.3 Director of Staff | | |
| | results): sub-q (s | subcutaneous): | | | Development / designee will re-inservice licensed staff an | | |
| | | | | | QMAs regarding following | ıu | |
| | 60-150= 0 units | | | | physician orders related to e | ye | |
| | 151-200= 4 units | S | | | drop medication administrati | | |
| | 210-250= 8 units | : | | | 5/30/11. Unit Nurse Manage | | |
| | 251-300= 12 uni | ts | | | designees will review five (5) | | |
| | 301-350= 16 uni | ts | | | resident MARs with eye drop weekly per unit to ensure |)8 | |
| | 351-400= 20 uni | ts | | | physician order followed | | |
| | > (greater than) 4 | 100= 23 units | | | beginning week of 5/23/11 fo | or six | |
| | < (less than) 60 c | or >400 call MD." | | | (6) months. | | |
| | | | | | 1.4 The DON will report au | | |
| | A MAR dated 4/2 | 2011, indicated on 4/7/11 | | | findings to the Continuous Q Improvement (CQI) Committ | | |
| | | sident's blood sugar was | | | monthly for six (6) months w | | |
| | _ | of insulin were given | | | the next meeting to be held | | |
| | | dered 12 units. On | | | 5/31/11. The CQI Committee | | |
| | | , the resident's blood | | | monitor data presented for a | | |
| | | | | | trends, and determine if furth | ner | |
| | | nd 4 units of insulin were | | | monitoring is necessary for compliance. | | |
| | given instead of t | the ordered 12 untis | | | 1.5 Systemic changes will | be | |
| | A care plan for " | Diabetes," dated 2/3/11, | | | completed by 6/1/11. | | |
| | _ | rventionsAdminister | | | 2.1 Regarding resident #120 | _{).} | |
| | insulin sub q as o | | | | Unit Nurse Manager / design | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | | (X3) DATE S | SURVEY |
|--|----------------------|------------------------------|--------------------------------------|--------|--|-------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLI | ETED |
| | | 155214 | B. WIN | | | 05/02/20 | 011 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ANCISCAN DRIVE | | |
| OT ANITL | ONY HOME | | | 1 | N POINT, IN46307 | | |
| STANTI | IONT HOME | | | CROW | N FOINT, IN40307 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | | | | immediately assessed reside | | |
| | During an intervi | iew with LPN #10, the 3 | | | 4/27/11 with no adverse read | ctions | |
| | · - | ager, on 4/28/11 at 11:15 | | | noted. Unit Nurse Manager | , | |
| | | ed the insulin was not | | | notified physician and family | or | |
| | · · | | | | the occurrence on 4/27/11. 2.2 Unit Nurse Managers / | | |
| | l = | on 4/7 and 4/18. She | | | designees reviewed current | | |
| | indicated 12 unit | s should have been given. | | | physician orders and MARs | of | |
| | | | | | residents receiving blood | - | |
| | B. A Physician's | Order, dated 4/20/11 at 5 | | | pressure medication on 4/27 | /11 to | |
| | p.m., indicated " | Lotrimin Cream apply to | | | ensure physician orders follo | wed | |
| | l * ' | (twice a day) x (times) 1 | | | with no other deficiencies no | ted. | |
| | wk (week)" | (twice a day) is (times) i | | | 2.3 Director of Staff | | |
| | WK (WCCK) | | | | Development / designee will | | |
| | | | | | re-inservice licensed staff ar | ıd | |
| | ı | der, dated 4/22/11 noted | | | QMAs regarding following | المما | |
| | at 2 p.m., indicat | ed "D/C (discontinue) | | | physician orders related to b pressure medication | 1000 | |
| | Lotrimin" | | | | administration by 5/30/11. U | _{Init} | |
| | | | | | Nurse Managers / designees | | |
| | A TAR (Treatme | nt Administration | | | review five (5) resident MAR | | |
| | Record), dated 4 | | | | with blood pressure medicat | | |
| | · / · | | | | weekly per unit to ensure | | |
| | | apply to glans penis BID | | | physician order followed | | |
| | x 1 wk." There v | | | | beginning week of 5/23/11 fo | or six | |
| | documentation o | f the Lotrimin ever being | | | (6) months. | | |
| | applied before it | was discontinued on 4/22 | | | 2.4 The DON will report au | | |
| | at 2 p.m. | | | | findings to the Continuous Q | | |
| | | | | | Improvement (CQI) Committ monthly for six (6) months w | | |
| | During an intervi | iew, LPN #10, with the | | | the next meeting to be held | | |
| | | nager, on 4/28/11 at | | | 5/31/11. The CQI Committee | _{e will} | |
| | | • | | | monitor data presented for a | | |
| | · · | ndicated the Lotrimin | | | trends, and determine if furth | · . | |
| | ı | ordered until it was | | | monitoring is necessary for | | |
| | discontinued. | | | | compliance. | | |
| | | | | | 2.5 Systemic changes will | be | |
| | 5. Resident #26' | s record was reviewed on | | | completed by 6/1/11. | | |
| | | a.m. Resident #26's | | | 2.1 Degerding resident #400 | , | |
| | | | | | 3.1 Regarding resident #162 Nurse Practitioner was alrea | | |
| | _ | ed, but were not limited | | | notified on 4/8/11 of the | uy | |
| | to, cerebral palsy | , seizures, and arthritis. | | | Houlied Oil 4/0/11 Of tile | | |

| [| | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|-----------|----------------------|------------------------------|------------|------------|--|--------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPLETED |
| | | 155214 | B. WIN | | | 05/02/2011 |
| | | | | _ | ADDRESS, CITY, STATE, ZIP CODE | ļ |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ANCISCAN DRIVE | |
| ST ANTH | IONY HOME | | | 1 | N POINT, IN46307 | |
| | | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | _ | TAG | | DATE |
| | | | | | occurrence on 4/7/11 and 4/8 | 8/11 |
| | A Physician's Or | der, dated 4/14/11 at 1:20 | | | by LPN #2. | |
| | p.m., indicated " | Erythromycin (antibiotic) | | | 3.2 Unit Nurse Managers / designees reviewed current | |
| | 0.5% oint (ointm | ent)QID (four times a | | | physician orders and MARs | of |
| | , | er eye lid x 5 days" | | | residents receiving nasal spr | |
| | duy) to best bow | er eye na x 3 days | | | on 4/27/11 to ensure physicia | |
| | | /2011 : 4: 4 | | | orders followed with no other | |
| | A MAR, dated 4/ | | | | deficiencies noted. | |
| | "Erythromycin (a | antibiotic) 0.5% oint | | | 3.3 Director of Staff | |
| | (ointment)QID | (four times a day) to Left | | | Development / designee will | |
| | Lower eye lid x 5 | 5 days" It was initialed | | | re-inservice licensed staff an | d |
| | as given on the fo | ollowing dates and times: | | | QMAs regarding following | |
| | | | | | physician orders related to n | |
| | 0 a m an 4/15 4 | /16 4/17 4/19 4/10 and | | | spray administration by 5/30, Unit Nurse Managers / desig | |
| | • | /16, 4/17, 4/18, 4/19 and | | | will review five (5) resident M | |
| | 4/20 (6 days) | | | | with nasal spray weekly per | |
| | | /16, 4/17, 4/18, 4/19 and | | | to ensure physician order | |
| | 4/20 (6 days) | | | | followed beginning week of | |
| | 5 p.m. on 4/15, 4 | /16, 4/17, 4/18, and 4/19 | | | 5/23/11 for six (6) months. | |
| | (5 days) | | | | 3.4 The DON will report au | |
| | | /16, 4/17, 4/18, and 4/19 | | | findings to the Continuous Q | |
| | (5 days) | 710, 1/17, 1/10, and 1/19 | | | Improvement (CQI) Committ | |
| | (3 days) | | | | monthly for six (6) months wi | ith |
| | | | | | the next meeting to be held 5/31/11. The CQI Committee | النبد |
| | _ | iew, LPN #13, with | | | monitor data presented for a | |
| | Second Floor Un | it Manager on 4/26/11 at | | | trends, and determine if furth | - 1 |
| | 2:56 p.m., she in | dicated the order was not | | | monitoring is necessary for | |
| | followed for the | Erythromycin, an extra | | | compliance. | |
| | | on 4/20 at 9 a.m. and 1 | | | 3.5 Systemic changes will | be |
| | | | | | completed by 6/1/11. | |
| | p.m. | | | | | |
| | | | | | 4.1-A Regarding resident #1 | |
| | 3.1-35(g)(2) | | | | on 4/28/11 resident was at th | ne |
| | | | | | hospital. | , |
| | | | | | 4.2-A Unit Nurse Managers designees reviewed current | ¹ |
| | | | | | diabetic flow sheets related t | _ |
| | | | | | blood glucose monitoring and | |
| | | | | | sliding scales on 4/28/11 with | |
| | | | | | 3 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | | E CONSTRUCTION 00 | COMPLE | |
|-----------|-------------------------------|--|------------------------|---|---|----------------------|
| | | 155214 | A. BUILDING B. WING | | 05/02/20 | |
| | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | FRANCISCAN DRIVE | | |
| ST ANTH | ONY HOME | | CR | OWN POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTI | ON | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION) | PREFIX | CROSS-REFERENCED TO THE APPRO | BE PRIATE | |
| | (EACH DEFICIEN | | | other deficiencies noted. 4.3-A Director of Staff Development / designee re-inservice licensed staf QMAs regarding facility medication policy and pro- related to blood glucose monitoring and sliding sc 5/30/11. DON reviewed of practices with Pharmacy, Pharmacy to supply blood glucose monitoring recon- chronological time order beginning 6/1/11. Unit N Managers / designees wi five (5) resident diabetic of sheets of those receiving glucose monitoring and s scale weekly per unit to e physician order followed beginning week of 5/23/1 (6) months. 4.4-A The DON will repo- findings to the Continuous Improvement (CQI) Commonthly for six (6) month the next meeting to be he 5/31/11. The CQI Commonitor data presented for trends, and determine if f monitoring is necessary f compliance. 4.5-A Systemic changes completed by 6/1/11. | will f and ocedure ales by current with d ds in urse Il review blood liding ensure 1 for six rt audit s Quality mittee s with eld ittee will or any urther or will be | (X5) COMPLETION DATE |
| | | | | 4.1-B Regarding residen on 4/28/11 resident was a | | |
| | | | | hospital. | oro / | |
| | | | | 4.2-B Unit Nurse Manag designees reviewed phys | I . | |
| | | | | orders and TARs for accu | ıracy | |
| | | | | related to Lotrimin Cream | on | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 05/02/2011 | | | |
|---|----------------------|--|--|--|---|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 4/28/11 with no other deficient noted. 4.3-B Director of Staff Development / designee will re-inservice licensed staff at QMAs regarding facility treat application procedure by 5/3 Unit Nurse Managers / designed will review five (5) residents treatment orders weekly per to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-B The DON will report a findings to the Continuous Comprovement (CQI) Commit monthly for six (6) months weekly per six (6) months weekly per six (6) months. | encies Ind Ind Itment B0/11. Ignees With I unit Budit Quality Itee | | | |
| | | | | the next meeting to be held 5/31/11. The CQI Committee monitor data presented for a trends, and determine if furt monitoring is necessary for compliance. 4.5-B Systemic changes wi completed by 6/1/11. 5.1 Regarding resident #26 Nurse Manager assessed resident on 4/26/11 with no adverse reactions noted. U Nurse Manager notified phy and family of the occurrence 4/26/11. 5.2 Unit Nurse Managers / designees reviewed current physician orders and MARs residents receiving eye drop 4/26/11 to ensure physician orders followed with no other deficiencies noted. 5.3 Director of Staff Development / designee will | any her II be , Unit nit sician e on of os on | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155214 05/02/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DRIVE ST ANTHONY HOME **CROWN POINT, IN46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE re-inservice licensed staff and QMAs regarding following physician orders related to eye drop medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with eye drops weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 5.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 5.5 Systemic changes will be completed by 6/1/11. Each resident must receive and the facility F0309 must provide the necessary care and services SS=D to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. F0309 Regarding resident #135. 06/01/2011 Based on record review and Unit Nurse Manager / designee interview, the facility failed immediately assessed resident on 4/26/11 with no adverse reactions to provide the necessary noted. Unit Nurse Manager notified physician and family of care and services related to the occurrence on 4/26/11. Unit Nurse Managers / notifying the resident's designees reviewed current 24-hour reports related to physician and obtaining an physician notification on 4/26/11 with no other deficiencies noted order to treat the resident's at that time.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION 00 | (X3) DATE S COMPL | | |
|---|--|---|------------------|---|--|---------------------|------------|
| ANDILAN | OF CORRECTION | 155214 | A. BUI B. WIN | LDING | | 05/02/2 | |
| NAME OF F | PROVIDER OR SUPPLIER | | b. WIN | | DDRESS, CITY, STATE, ZIP CODE | | |
| | IONY HOME | | | 1 | ANCISCAN DRIVE N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | 1 | ID | | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | 1.3 Director of Staff | | DATE |
| | constipation for 1 of 26 | | | | Development / designee will | | |
| | residents re | eviewed for the | | | re-inservice licensed staff regarding physician notificati | on by | |
| | necessary c | care and services | | | 5/30/11. Unit Nurse Manage designees will review five (5) | ers / | |
| | in a total sa | imple of 26. | | | 24-hours reports per unit we | ekly | |
| | (Resident # | 4135) | | | to ensure physician notification completed for six (6) months | | |
| | Findings include: | | | | beginning the week of 5/23/1 1.4 The DON will report au findings to the Continuous Q Improvement (CQI) Committ monthly for six (6) months with e next meeting to be held | dit uality ee | |
| | 1. Resident | #135's record | | | 5/31/11. The CQI Committee | | |
| | was review | red on 4/26/11 at | | monitor data presented for any trends, and determine if further | | | |
| | 2:30 p.m. | Resident #135's | | | monitoring is necessary for compliance. | | |
| | diagnoses i | ncluded, but | | | 1.5 Systemic changes will completed by 6/1/11. | be | |
| | were not lin | mited to, | | | | | |
| | hypertension | on, stroke, and | | | | | |
| | osteoporosi | | | | | | |
| | obte operous | | | | | | |
| | updated 4/1 "At risk for constipation per MD ord | n, dated 6/21/10 11/11, indicated nStool softener der. Monitor of stool. Laxative | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE S | | |
|--|---------------------------|--|-------------------|----------------|--|---------|--------------------|
| | | 155214 | A. BUII B. WIN | | | 05/02/2 | 011 |
| NAME OF F | PROVIDER OR SUPPLIER | ! | <u> </u> | | ADDRESS, CITY, STATE, ZIP CODE | | |
| ST ANTH | IONY HOME | | | 1 | ANCISCAN DRIVE N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | COMPLETION DATE |
| | PRN (as ne | eeded) per MD | | | | | |
| | order. Incre | ease fluids to | | | | | |
| | resident's to | olerance" | | | | | |
| | | | | | | | |
| | On 4/25/11 | at 2:00 p.m., | | | | | |
| | CNA #3 re | ported to LPN #6 | | | | | |
| | that resider | nt #135's stool | | | | | |
| | was "real re | eal hard." | | | | | |
| | | | | | | | |
| | The resider | nt's bowel | | | | | |
| | movement | monitoring | | | | | |
| | | 1 3/26/11 through | | | | | |
| | $\frac{1}{4/26/11}$, inc | C | | | | | |
| | | d hard stools on | | | | | |
| | | 1/11, 4/2/11, | | | | | |
| | ĺ | 0/11, 4/16/11, | | | | | |
| | and 4/25/11 | | | | | | |
| | | - • | | | | | |
| | The resider | nt's nurses' notes, | | | | | |
| | dated 4/25/ | , | | | | | |
| | | tion to indicate | | | | | |
| | | t had hard stools. | | | | | |
| | uic restuell | i nau naru sioois. | | | | | |
| | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL | ETED | | |
|---|--|---|---|---------------------|---|------|----------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE | |
| | 4/26/11 at 2 #9,the 3A a Unit Manageresident had hard stools to see about resident a sign should have something the CNA regresident was stools. During an a 4/26/11 at 3 #9,the 3A a Unit Manageshe had got | yesterday when | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | |
|--|--|---|--|--------|--|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 155214 | B. WING | | | 05/02/20 | 011 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ſΕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | constipatio | n) for the | | | | | |
| | resident. | | | | | | |
| | 3.1-37(a) | | | | | | |
| F0315 SS=D | assessment, the firesident who enteresident who enteresident's clinical that catheterization resident who is incompropriate treatment urinary tract infect normal bladder fur Based on observation interview, the fact catheter tubing we reduce the risk for residents with incomplete of 26 residents with incomplete of 26 residents with incomplete of 26 residents. Findings include 1. During the interest of the properties of th | ation, record review and cility failed to ensure vas positioned correctly to or infection for 2 of 3 dwelling catheters in a idents reviewed for ters. (Resident #180 and | F0: | 315 | 1.1 Regarding resident #18 on 4/25/11 while resident was the recliner, the CNA immedi properly positioned the Foley catheter tubing. On 4/27/11, Nurse Manager assisted resi #180 with adjusting her Foley tubing using standard precau and enabling resident to confambulating while maintaining infection control protocols. Pand PTA#5 were directed to their hands after touching / readjusting the catheter tubin 1.2 Unit Nurse Managers / designees completed rounds 4/27/11 for all residents curre with a Foley catheter to ensu tubing was positioned correct. | s in liately / Unit lident ly utions linue ly wash ling. | 06/01/2011 |

| STATEMEN | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | | SURVEY |
|---------------|---|--|---------|---------------|--|------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 155214 | B. WIN | | | 05/02/2 | 011 |
| | | II. | P | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ANCISCAN DRIVE | | |
| ST ANTH | HONY HOME | | | 1 | N POINT, IN46307 | | |
| | | CTATE OF DEPLOYED OF | | | | | 975) |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | | ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| IAG | | · · · · · · · · · · · · · · · · · · · | | IAG | with no other deficiencies no | tod | DAIL |
| | | ident's catheter tubing | | | 1.3 Director of Staff | icu. | |
| | | e floor. The 3D Unit | | | Development / designee will | | |
| | | ed the catheter tubing | | | re-inservice nursing and ther | ару | |
| | should not be on | the floor. | | | staff regarding proper handli | - | |
| | | | | | and placement of Foley cath | | |
| | Resident #180 w | as observed on 4/27/11 at | | | tubing, and hand-washing by | | |
| | 11:25 a.m., ambi | ulating in the hallway | | | 5/30/11. Unit Nurse Manage designees will complete audi | | |
| | | nerapist (PT) #4 and | | | five (5) residents who require | | |
| | <u>-</u> | y Assistant (PTA) #5. PT | | | Foley catheter weekly per un | | |
| | | along side the resident | | | six (6) months to ensure prop | per | |
| | _ | wheelchair behind them. | | | placement and handling of F | oley | |
| | | theter bag was connected | | | catheter tubing on all shifts | | |
| | | · · | | | beginning the week of 5/23/1 | | |
| | | e wheelchair and Resident | | | Director of Therapy / designed audit residents who require a | | |
| | | he catheter was being | | | Foley catheter and therapy | 1 | |
| | l ^ | and PT #4 adjusted the | | | services five (5) times per we | eek | |
| | catheter bag and | tubing by bringing the | | | for six (6) months beginning | the | |
| | catheter bag and | tubing forward under the | | | week of 5/23/11 to ensure pr | | |
| | wheelchair and h | nooking the catheter bag | | | placement and handling of F | oley | |
| | onto the resident | 's walker. The catheter | | | catheter tubing. 1.4 The DON and the Ther | anv | |
| | tubing was layin | g on the floor and as the | | | Director will report audit findi | | |
| | resident was aml | bulating the tubing was | | | to the Continuous Quality | 5 - | |
| | | nd kicked by the resident's | | | Improvement (CQI) Committe | ee | |
| | feet. | | | | monthly for six (6) months wi | ith | |
| | Teet. | | | | the next meeting to be held | ••• | |
| | Dagidant #190'g | record was reviewed on | | | 5/31/11. The CQI Committee monitor data presented for a | | |
| | | | | | trends, and determine if furth | • | |
| | 1 ^ | o.m. Resident #180's | | | monitoring is necessary for | | |
| | _ | led, but were not limited | | | compliance. | | |
| | 1 | itus, personal history of | | | 1.5 Systemic changes will | be | |
| | urinary tract infe | ection (UTI), and debility. | | | completed by 6/1/11. | | |
| | | | | | 2.1 Degarding resident #400 |) the | |
| | An Admission MDS (Minimum Data Set) | | | | 2.1 Regarding resident #183 Foley catheter was removed | | |
| | assessment, date | d 3/23/11, indicated the | | | when the 24-hour urine was | | |
| | · · | 15 for cognitive status | | | obtained on 4/26/11. | | |
| | | the resident is cognitively | | | 2.2 Unit Nurse Managers / | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|------------------------|------------------------------|-------------------|--------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | , DIII | LDDIG | 00 | COMPL | ETED |
| | | 155214 | A. BUII B. WIN | | | 05/02/2 | 011 |
| | | | B. WIN | _ | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | 1 | | | |
| OT ANITL | IONY HOME | | | 1 | ANCISCAN DRIVE N POINT, IN46307 | | |
| | IONT HOIVIE | | | CROW | N FOINT, IN46307 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE. | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | intact. | | | | designees completed rounds | | |
| | | | | | 4/27/11 for all residents curr | , , | |
| | The CAA (Care | Area Assessment), dated | | | with a Foley catheter to ensi tubing was positioned correc | | |
| | , | ed Resident #180 was | | | with no other deficiencies no | | |
| | - | acility with a diagnosis of | | | 2.3 Director of Staff | ica. | |
| | | denity with a diagnosis of | | | Development / designee will | | |
| | a recent UTI. | | | | re-inservice nursing staff | | |
| | | | | | regarding proper handling a | nd | |
| | - | ed 3/17/11, indicated the | | | placement of Foley catheter | | |
| | resident was at r | isk for urinary tract | | | tubing by 5/30/11. Unit Nurs | se | |
| | infection. | | | | Managers / designees will | | |
| | | | | | complete audit of five (5) residents who require a Fole | | |
| | A nurses' note, d | ated 4/27/11 at 10:31 | | | catheter weekly per unit for | • | |
| | • | 9:30 am, Resident | | | months to ensure proper | oix (o) | |
| | - | or sitting on buttocks | | | placement and handling of F | oley | |
| | | _ | | | catheter tubing on all shifts | · | |
| | | ecliner with sensor pad in | | | beginning the week of 5/23/ | | |
| | | gResident more | | | 2.4 The DON will report at | | |
| | confused than us | sual." | | | findings to the Continuous C | | |
| | | | | | Improvement (CQI) Commit | | |
| | A nurses' note, d | ated 4/27/11 at 11:30 | | | monthly for six (6) months w the next meeting to be held | 1111 | |
| | a.m., indicated tl | he nurse had called the | | | 5/31/11. The CQI Committee | e will | |
| | • | ian concerning the | | | monitor data presented for a | | |
| | | d increased confusion. | | | trends, and determine if furtl | | |
| | | indicated the physician | | | monitoring is necessary for | | |
| | | | | | compliance. | | |
| | | rinalysis and urine | | | 2.5 Systemic changes will | be | |
| | | itivity to be done on | | | completed by 6/1/11. | | |
| | 4/28/11. | | | | | | |
| | | | | | | | |
| | During an interv | iew on 4/27/11 at 11:35 | | | | | |
| | a.m.,LPN #10 in | dicated the catheter | | | | | |
| | • | ot be on the floor. | | | | | |
| | | | | | | | |
| | During an interv | iew on 4/27/11 at 2:10 | | | | | |
| | _ | ndicated the resident had | | | | | |
| | * | | | | | | |
| | railen this morni | ng and had an increase in | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2011 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214 | | A. BUIL B. WING | DING | 00 | COMPL 05/02/2 | ETED | |
|--|---|---|----------|---------------------|--|-------------|----------------------------|
| | PROVIDER OR SUPPLIER | | P | STREET AI | DDRESS, CITY, STATE, ZIP CODE NCISCAN DRIVE POINT, IN46307 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Έ | (X5) COMPLETION DATE |
| | | ndicated they were going on the resident today. | | | | | |
| | 4/25/11 at 1:39 p up in wheelchair | 3 was observed on a.m., in her room sitting. The resident's catheter eved laying on the floor. | | | | | |
| | 4/25/11 at 1:45 p diagnoses includ | record was reviewed on e.m. Resident #183's ed, but were not limited art failure and kidney | | | | | |
| | | der, dated 4/25/11 catheter to obtain a 24 e. | | | | | |
| | 3.1-41(a)(2) | | | | | | |
| F0360 SS=D | nourishing, palata meets the daily nu needs of each res Based on observ interview, the fac residents' diets, v | ble, well-balanced diet that thritional and special dietary ident. ation, record review, and cility failed to provide which met the special each resident, for 2 of 10 | F0. | 360 | 1.1 Regarding resident #78 yogurt was provided to reside immediately on 4/26/11.1.2 Dietary Service Managedesignee monitored tray lines | ent er / | 06/01/2011 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HTE311 Facility ID:

000120

If continuation sheet

Page 28 of 43

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|---|---|---|----------|------------------|--|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | ETED |
| | | 155214 | B. WIN | | | 05/02/2 | 011 |
| | | 1 | B. ((1)) | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | 1 | ANCISCAN DRIVE | | |
| ST ANTH | ONY HOME | | | 1 | N POINT, IN46307 | | |
| | | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION DATE |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | the next nine (9) meals (4/27 | 7/44 | DATE |
| | | ceived supplements in a | | | 4/29/11) for supplements give | | |
| | 1 | 6 residents. (Residents | | | ordered with no other deficie | | |
| | #78 and #135) | | | | noted. Registered Dietitian a | | |
| | | | | | Dietary Service Manager aud | | |
| | Findings include: | | | | all current resident physician | | |
| | 1 D :1 ///701 | 1 1 4/27/11 | | | ordered diets and nutritional | | |
| | | cord was reviewed on 4/27/11 ent #78's diagnoses included, | | | interventions against tray tick | cets | |
| | _ | to, Alzheimer's Disease, | | | with no deficiencies noted. 1.3 Dietary Service Manag | or / | |
| | anxiety, and osteop | | | | designee will re-inservice die | | |
| | ,, | | | | staff by 5/30/11 regarding | · tai y | |
| | A Physician's Order | r, dated 3/23/11, indicated | | | providing diets and nutritional | ıl | |
| | "Add yogurt to lunc | ch and supper to address low | | | supplements per physician o | rders | |
| | protein stores" | | | | and tray accuracy. Dietary | | |
| | | | | | Management designee will a | | |
| | | observed on 4/26/11 at 5:12 | | | twenty (20) trays for accurac three (3) times per week for | - | |
| | _ | eimer's Unit dining room. | | | (6) months beginning the we | | |
| | | red a roast beef sandwich, li, and grapes for the supper | | | 5/23/11. Registered Dietitiar | | |
| | | did not receive yogurt. | | | designee will audit fifteen (15 | | |
| | | ara not receive yogart. | | | diet order changes weekly o | n all | |
| | During an interview | with RN #8 on 4/26/11 at | | | units against tray tickets to | | |
| | 5:15 p.m., she indic | ated the resident did not get a | | | ensure accurate data entry for | | |
| | | She indicated she would call | | | (6) months beginning the we 5/23/11. | ek oi | |
| | the kitchen to send | one up. | | | 1.4 Dietary Service Manag | er | |
| | | | | | and Registered Dietitian will | | |
| | 2. Resident | t #135's record | | | report audit findings to the | | |
| | woo roviou | ved on 4/26/11 at | | | Continuous Quality Improver | | |
| | was ieview | /eu on 4/20/11 at | | | (CQI) Committee monthly for (6) months with the next meet | | |
| | 2:30 p.m. | Resident #135's | | | to be held 5/31/11. The CQI | ting | |
| | diagnoses | included, but | | | Committee will monitor data | _1 | |
| | | • | | | presented for any trends, and determine if further monitorin | | |
| | were not limited to, hypertension, stroke, and | | | | necessary for compliance. | 9 10 | |
| | | | | | 1.5 Systemic changes will | be | |
| | | · · | | | completed by 6/1/11. | | |
| | osteoporosis. | | | | 2.1 Regarding resident #135 | 5, | |
| | | | | | resident was provided magic | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | ONSTRUCTION 00 | (X3) DATE COMPL | | |
|--|----------------------|------------------------------|------------------|-------------------|---|----------|------------|
| AND LEAN | or course now | 155214 | A. BUI B. WIN | LDING | | 05/02/2 | |
| NAME OF F | PROVIDER OR SUPPLIER | | p. wii | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| | IONY HOME | | | 1 | ANCISCAN DRIVE N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | N 1 OIN 1, IN 40307 | | (X5) |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | JΈ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | the evening of 4/26/11. | | DATE |
| | A physiciai | n's order, dated | | | 2.2 See 1.2 above. | | |
| | 4/12/11, ind | dicated "magic | | | 2.3 See 1.3 above. 2.4 See 1.4 above. | | |
| | cup (a supp | olement) @ (at) | | | 2.5 See 1.5 above. | | |
| | all meals." | | | | | | |
| | | | | | | | |
| | Resident #1 | 135 was | | | | | |
| | observed or | n 4/26/11 at | | | | | |
| | 12:28 p.m | during the noon | | | | | |
| | • | resident had | | | | | |
| | | er meal but had | | | | | |
| | | | | | | | |
| | | d a magic cup | | | | | |
| | with her mo | eal. | | | | | |
| | | | | | | | |
| | During an i | interview on | | | | | |
| | 4/26/11 at 2 | 2:42 p.m., LPN | | | | | |
| | #7 indicate | d the resident | | | | | |
| | did not rece | eive a magic cup | | | | | |
| | with her lu | • | | | | | |
| | | he needed to get | | | | | |
| | | • | | | | | |
| | | ne dietician and | | | | | |
| | let her know | W. | | | | | |
| | | | | | | | |
| | 3.1-20(a) | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | identification number: 155214 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | (x3) DATE SURVEY COMPLETED 05/02/2011 | |
|---|--|--|--|---|---|--|
| | PROVIDER OR SUPPLIER | | STREET A | ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | (X5) COMPLETION DATE | |
| F0363 SS=D | residents in accord recommended die and Nutrition Boar Council, National A prepared in advan Based on observa interview, the fact menus related to observed for 1 of | tary allowances of the Food d of the National Research Academy of Sciences; be ce; and be followed. Action, record review and cility failed to follow desserts for 2 of 2 meals for 23 residents observed in a sample of 26 lent #183) | F0363 | 1.1 Regarding resident #1 Registered Dietitian provide resident with the menued de immediately with lunch mea 4/26/11. Registered Dietitia provided resident with the menued dessert prior to end evening meal on 4/26/11. 1.2 Dietary Service Manad designee monitored tray line the next nine (9) meals (4/2 4/29/11) for supplements givent of the resident with no other deficient oted. Registered Dietitian Dietary Service Manager au all current resident physicial ordered diets and nutritional interventions against tray tic with no deficiencies noted. 1.3 Dietary Service Manad designee will re-inservice die | essert I on I on I of ger / es for 7/11 — ven as encies and idited in I ckets | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | (X3) DATE S COMPL | | |
|--|---|--|----------------------|------------------|---|--|--------------------|
| 12.1212111 | | 155214 | | LDING | | 05/02/2 | |
| | | | B. WIN | | DDRESS, CITY, STATE, ZIP CODE | | - ' |
| NAME OF F | PROVIDER OR SUPPLIER | | 203 FRANCISCAN DRIVE | | | | |
| | IONY HOME | | CROWN POINT, IN46307 | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | • | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION DATE |
| IAU | 1. Resident #183 room sitting up it 12:20 p.m. The r noon meal tray, v Lemon Pepper C Potatoes, peas, at resident did not r Sherbet Gelatin t The resident indi | 8 was observed in her n her bed on 4/26/11 at resident received her which consisted of | | IAU | staff by 5/30/11 regarding providing diets and nutritional supplements per physician of and tray accuracy. Dietary Management designee will atwenty (20) trays for accuracy three (3) times per week for (6) months beginning the web 5/23/11. Registered Dietitiar designee will audit fifteen (15 diet order changes weekly of units against tray tickets to ensure accurate data entry for (6) months beginning the web 5/23/11. 1.4 Dietary Service Managand Registered Dietitian will report audit findings to the Continuous Quality Improver (CQI) Committee monthly for (6) months with the next meet to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitorin necessary for compliance. 1.5 Systemic changes will completed by 6/1/11. | udit y six ek of n / 5) n all or six ek of er ment r six eting d | DATE |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | INSTRUCTION 00 | (X3) DATE : COMPL | |
|-----------|---------------------------------|--|--------|--------|--|----------------------|------------|
| | | 155214 | | LDING | | 05/02/2 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1 | ANCISCAN DRIVE | | |
| ST ANTH | IONY HOME | | | 1 | N POINT, IN46307 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | JΈ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | as observed on 4/26/11 at | | | | | |
| | - | room sitting up in her | | | | | |
| | | at received her evening | | | | | |
| | meal, which cons | sisted of a Philly Style | | | | | |
| | Steak sandwich, | french fries, and | | | | | |
| | broccoli. The res | sident did not receive the | | | | | |
| | grapes for desser | t as the menu indicated. | | | | | |
| | | | | | | | |
| | During an intervi | iew on 4/26/11 at 5:23 | | | | | |
| | p.m., the RD (Re | egistered Dietician) | | | | | |
| | indicated the firs | t time the resident had a | | | | | |
| | dessert it "just wa | asn't the right one." The | | | | | |
| | RD indicated the | resident's dessert "was | | | | | |
| | missed" during tl | | | | | | |
| | | | | | | | |
| | Resident #183's 1 | record was reviewed on | | | | | |
| | 4/25/11 at 1:45 p | .m. Resident #183's | | | | | |
| | _ | ed, but were not limited | | | | | |
| | _ | art failure and kidney | | | | | |
| | failure. | | | | | | |
| | TWITTE. | | | | | | |
| | A physician's ord | ler_dated 4/7/11 | | | | | |
| | indicated a regula | | | | | | |
| | condiments. | ar aret with aret | | | | | |
| | condiments. | | | | | | |
| | 3.1-20(i)(1) | | | | | | |
| | 3.1-20(i)(4) | | | | | | |
| | 5.1 20(1)(¬) | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (X3) DATE SU COMPLET | | | ETED | | |
|--|--|---|----------|------------|--|---------|------------|
| | | 155214 | B. WING | 3 <u> </u> | | 05/02/2 | 011 |
| | PROVIDER OR SUPPLIER | | • | 203 FR | NDDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | 1 ' | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENC | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | <u> </u> | TAG | DEFICIENCY) | | DATE |
| F0371 SS=F | considered satisfar local authorities; and (2) Store, prepare, under sanitary con Based on observation facility failed to sand serve food unrelated to, a black plastic part inside located on 2 of 3 floor), this had the residents who residents who residents who residents' food was plattered food in the 2B dining room residents who eat the 3A d | distribute and serve food diditions attion and interview, the store, prepare, distribute ander sanitary conditions at oily substance on a se 2 of 3 ice machines are potential to affect 107 side on the first and the facility and failed to crowaves used for ere clean related to dried, aside the microwave in the dining room and the dining room and the dining room. | F0. | 371 | 1.1 The ice machine located the Nurse's station on the firs floor was cleaned on 4/26/11 1.2 The Director of Maintena and the Director of Housekee / designee inspected all facili machines on 4/27/11 for presence of black substance any deficiencies noted correct at that time. 1.3 The Director of Maintena / designee evaluated current cleaning schedule for ice machines as well as current manufacturer guidelines for cleaning of ice machines; bas on same, cleaning / maintena schedule revised and implemented by week of 5/23. The Director of Staff Development / designee will re-inservice nursing, dietary, maintenance and housekeep staff regarding ice machine cleanliness by 5/30/11. Dieta Management / designee will inspect ice machines weekly six (6) months for cleanliness beginning week of 5/23/11 w additional cleaning to be completed at that time if need 1.4 Dietary Management will report audit findings to the | et | 06/01/2011 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|---|----------------------|------------------------------|---------|----------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | DING | 00 | COMPL | ETED |
| | | 155214 | B. WIN | | | 05/02/2 | 011 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ANCISCAN DRIVE | | |
| ST ANTH | IONY HOME | | | | N POINT, IN46307 | | |
| | | | | <u> </u> | 41 On41, 114-0007 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TΕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | | | DATE |
| | | ine located at the Nurses' | | | Continuous Quality Improver (CQI) Committee monthly for | | |
| | Station on the fire | rst floor had a black | | | (6) months with the next mee | | |
| | substance on the | white plastic part inside | | | to be held 5/31/11. The CQI | | |
| | of the ice machin | ne. The ice machine was | | | Committee will monitor data | | |
| | full of ice. | | | | presented for any trends, an | d | |
| | | | | | determine if further monitoring | | |
| | During on interv | iew at the time of the | | | necessary for compliance. | | |
| | | | | | 1.5 Systemic changes will b | е | |
| | · · | Director of Maintenance | | | completed by 6/1/11. | | |
| | | machine had been | | | 2.1 The ice machine located | lon | |
| | cleaned last mon | th. He indicated the | | | the second floor was cleaned | | |
| | facility does not | use enough ice and it lays | | | 4/27/11. | J 011 | |
| | on the plastic and | d the moisture causes the | | | 2.2 See 1.2 above. | | |
| | black substance. | | | | 2.3 See 1.3 above. | | |
| | | | | | 2.4 See 1.4 above. | | |
| | 2 The ice mach | ine located on the second | | | 2.5 See 1.5 above. | | |
| | | substance on the white | | | O.4. The maintaining leaded | 41 | |
| | | | | | 3.1 The microwave located2B dining room was cleaned | | |
| | | e of the ice machine. The | | | 4/26/11. | OII | |
| | ice machine was | full. | | | 3.2 The Director of | | |
| | | | | | Housekeeping inspected all | | |
| | During an interv | iew at the time of the | | | microwaves used for residen | ıt's | |
| | observation, the | Director of Maintenance | | | food on 4/27/11 with any | | |
| | indicated he thou | ight it was from the | | | deficiencies noted corrected | at | |
| | | ce because the ice is not | | | that time. | | |
| | used enough He | e indicated they would | | | 3.3 The Director of Staff | | |
| | | y cleaning schedule. | | | Development / designee will re-inservice nursing, dietary | and | |
| | put it on a weeki | y cleaning schedule. | | | housekeeping staff regarding | | |
| | 701 A 1 | | | | microwave cleanliness by | , | |
| | | or, at the time of the | | | 5/30/11. Dietary Manageme | | |
| | l | licated the ice was used | | | designee will inspect microw | aves | |
| | | nts who reside on the | | | used for resident's food for | | |
| | second floor. | | | | cleanliness two (2) times per | | |
| | | | | | week for six (6) months beging the week of 5/23/11. | nning | |
| | 3. The microwa | ve located in the 2B | | | 3.4 Dietary Management wil | | |
| | | splattered dried food on | | | report audit findings to the | " | |
| | the inside. | Transfer direction on | | | Continuous Quality Improver | ment | |
| | are morae. | | 1 | | · ' | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155214 | | (X2) MULT A. BUILDIN B. WING | | NSTRUCTION 00 | (X3) DATE S COMPL 05/02/2 | ETED | | |
|--|--|---|---|----------------|---------------------------------|-----------------------------------|----------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | | |
| ST ANTH (X4) ID PREFIX TAG | During an intervolution observation, the indicated the nur the microwave was a food. She indicated in the dining room had food splattered of the property observation, the indicated she wooknow about the resulting the control of the property of the proper | ve located in the 3A a large amount of dried in the inside. iew at the time of the Director of Housekeeping uld let the nursing staff microwave. esident's observed eating al in the 3A dining room | C II PRE | ROWN | | r six eting d eg is e | (X5) COMPLETION DATE | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | |
|--|----------------------|--|--|---|------------|---|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | , DIM DDIG | 00 | COMPLETED | |
| | | 155214 | A. BUILDING | | 05/02/2011 | |
| | | | B. WING | A DDDEGG CITY CTATE ZID CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| OT ANTH | IONIV LIONIE | | | ANCISCAN DRIVE | | |
| STANTH | IONY HOME | | CROW | N POINT, IN46307 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| F0441 | The facility must e | establish and maintain an | | | | |
| SS=F | | Program designed to provide | | | | |
| | | nd comfortable environment | | | | |
| | | nt the development and | | | | |
| | transmission of dis | sease and infection. | | | | |
| | (-) l-fti 0t- | ool Dan waren | | | | |
| | (a) Infection Contr | | | | | |
| | Program under wh | establish an Infection Control | | | | |
| | | ontrols, and prevents | | | | |
| | infections in the fa | · · | | | | |
| | | procedures, such as | | | | |
| | · · · | e applied to an individual | | | | |
| | resident; and | | | | | |
| | (3) Maintains a red | cord of incidents and | | | | |
| | corrective actions | related to infections. | | | | |
| | | | | | | |
| | (b) Preventing Spr | | | | | |
| | · · · | ction Control Program | | | | |
| | | resident needs isolation to | | | | |
| | | d of infection, the facility | | | | |
| | must isolate the re | | | | | |
| | | st prohibit employees with a | | | | |
| | | ease or infected skin t contact with residents or | | | | |
| | | contact will transmit the | | | | |
| | disease. | Contact will transmit the | | | | |
| | | st require staff to wash their | | | | |
| | · · · | direct resident contact for | | | | |
| | | ng is indicated by accepted | | | | |
| | professional practi | - | | | | |
| | | | | | | |
| | (c) Linens | | | | | |
| | | andle, store, process and | | | | |
| | • | as to prevent the spread of | | | | |
| | infection. | | | | | |
| | Based on o | bservation, | F0441 | 1.1 Upon notification on 4/ | | 1 |
| | | | | of the potential contaminatio | n of | |
| | record revi | ew, and | | an ice scoop being stored | | |
| | | • | | improperly, the Unit Nurse Manager on 3A hall assesse | d the | |
| | interview, 1 | the facility failed | | hydration cart with no deficie | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|--|--------|--|--|---------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUII | LDING | 00 | COMPL | LETED |
| | | 155214 | B. WIN | | | 05/02/2 | :011 |
| NAME OF F | PROVIDER OR SUPPLIER | <u>u</u> | - | STREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 1 | ANCISCAN DRIVE | | |
| ST ANTH | IONY HOME | | | CROWN | N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | `` | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION DATE |
| IAG | | | + | IAG | noted. | | DAIL |
| | to ensure in | nfection control | | | 1.2 On 4/25/11, Unit Nurse | ; | |
| | protocols v | vere practiced | | | Managers / designees asses all of the hydration carts that | | |
| | by licensed | l and unlicensed | | | contain an ice scoop and ice to ensure infection control | bin | |
| | staff related | d to handwashing | | | protocols were followed with | no | |
| | and positio | ning of catheter | | | other deficiencies noted. 1.3 The Director of Staff | | |
| | tubing to p | revent potential | | | Development / designee will re-inservice nursing staff | | |
| | contaminat | ion. This | | | regarding infection control protocols to prevent | | |
| | deficient pr | ractice had the | | | contamination related to prop placement of an ice scoop w | | |
| | potential to | affect 183 of | | | passing ice water to resident 5/30/11. Unit Nurse Manage | ts by | |
| | 183 resider | nts who reside in | | | designees will check each | | |
| | the facility | . (1st floor unit | | hydration cart on all units five (5) times per week for six (6) months | | | |
| | manager, P | hysical | | | to ensure infection control protocols to prevent | | |
| | Therapist # | 4, Physical | | | contamination related to proplacement of an ice scoop w | hile | |
| | Therapy As | ssistant #5, CNA | | | passing ice water to resident followed beginning the week | | |
| | #1, and Res | sidents #116 and | | | 5/23/11. 1.4 The DON will report au | ıdit | |
| | #180) | | | | findings to the Continuous Q | | |
| | | | | | Improvement (CQI) Committe | | |
| | | | | | monthly for six (6) months w | ith | |
| | Findings In | iclude. | | | the next meeting to be held 5/31/11. The CQI Committee | e will | |
| | 1 1110,11180 11 | | | | monitor data presented for a | ny | |
| | | | | | trends, and determine if furth | ıer | |
| | 1. CNA #1 | was observed | | | monitoring is necessary for compliance. | | |
| | on 4/25/11 | at 2:45 p.m., | | | 1.5 Systemic changes will | be | |
| | | • | | | completed by 6/1/11. | | |
| | passing ice | water on the 3A | | | 2.1 On 4/25/11 the Unit Nur Manager informed the CNA | | |

Facility ID:

| STATEMENT OF DEFICIENCIES X | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) | | (3) DATE SURVEY | | |
|-------------------------------|--|-----------------------------|---------------------------------|---|---|---|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | |
| 155214 | | 155214 | B. WING | | | 05/02/2011 | |
| NAME OF DROWINGS OR CUIDN IED | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1 | ANCISCAN DRIVE | | |
| ST ANTH | IONY HOME | | | CROW | N POINT, IN46307 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX TAG | · · | CY MUST BE PERCEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROFIDENCY) | | COMPLETION DATE | |
| IAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | + | IAG | uncovered ice scoop, who | DATE | |
| | hall. CNA #1 was observed to place the ice scoop on a paper towel between passing ice water to | | | | immediately removed the ice | ; | |
| | | | | scoop and ice bin from the hydration cart, and sent to I | | ietary | |
| | | | | | ictary | | |
| | | | | | 2.2 See 1.2 above. | | |
| | | | | | 2.3 See 1.3 above. 2.4 See 1.4 above. | | |
| | resident's rooms. | | | | 2.5 See 1.5 above. | | |
| | | | | | 3.1 Regarding resident #116 | | |
| | 2. There was an ice so | | | | adverse reactions were note related to LPN #12's techniq | | |
| | | • | | | while changing leg dressing | · • • • • • • • • • • • • • • • • • • • | |
| | lying uncovered on top of the ice container on 4/25/11 | | | | 4/26/11. | | |
| | | | | | 3.2 On 4/26/11, Unit Nurse Managers / designees round | led all | |
| | at 10:27 a.1 | m. on the 3B | | | units to remind nursing associates of following infect | | |
| | hall. Durin | ng an interview at | | | control protocols related to hand-washing with no other | | |
| | the time of the observation, the 3D Hall Unit Manager, | | | | deficiencies witnessed at that | at | |
| | | | | | time. 3.3 The Director of Staff | | |
| | indicated th | ne ice scoop | | | Development / designee will re-inservice licensed staff | | |
| | should hav | e been placed in | | | regarding infection control | | |
| | | • | | | protocols while performing a dressing change by 5/30/11. | | |
| | a plastic ba | ig. | | | Director of Staff Developmer | | |
| | | | | | designee will conduct two (2 | | |
| | 3. During a dressing change | | | | random supervised dressing changes weekly for six (6) | | |
| | on 4/26/11 | at 10:14 a.m., | | | months on all shifts with diffe | | |
| | | was observed to | | | of 5/23/11. | | |
| | , | | | | See 1.4 above. See 1.5 above. | | |
| | remove Resident #116's | | | | 230 1.0 45070. | | |
| | dressing fro | om her leg | | | 4.1 On 4/27/11, Unit Nurse | 100 | |
| | \mathcal{E} | | | | Manager assisted resident # with adjusting her Foley tubi | | |
| | | | | | | <u> </u> | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|------------------------------|--|--|----------------------------|--|---|------------|--|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING 00 | | 00 | COMPLETED | | |
| 155214 | | | | | 05/02/2011 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | • | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| ST ANTHONY HOME | | | | 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | |
| (X4) ID | | | | ID | 1 | (X5) | | |
| PREFIX | | CY MUST BE PERCEDED BY FULL | | PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | | |
| | wound. LPN #12 then cleansed the wounds and then removed her gloves and left the room to get the | | | | using standard precautions a enabling resident to continue | • | | |
| | | | | | ambulating while maintaining infection control protocols. | | | |
| | | | | | and PTA#5 were directed to their hands after touching / | | | |
| | | | | | readjusting the catheter tubin | ng. | | |
| | ointment for the wounds. | | | | 4.2 Unit Nurse Managers / designees completed rounds | | | |
| | LPN #12 tl | nen returned to | | | 4/27/11 for all residents curre with a Foley catheter to ensu | ure | | |
| | the room a | nd indicated she | | | tubing was positioned correct with no other deficiencies no | - 1 | | |
| | had the oin | tment in her | | | 4.3 Director of Staff Development / designee will | | | |
| | pocket. Sh | She indicated she re-inservice nursing regarding proper handling and placement | | | | ng | | |
| | had washed her hands after | | | | Foley catheter tubing by 5/30 Unit Nurse Managers / desig | 0/11. | | |
| | she had lef | t the resident's | | will complete five (5) a unit of residents who r Foley catheter weekly months to ensure prop placement and handlir | will complete five (5) audits | per | | |
| | room. She | then applied | | | Foley catheter weekly for six | | | |
| | gloves and | applied the | | | placement and handling of F | oley | | |
| | ointments t | to the wounds on | | | catheter tubing on all shifts beginning the week of 5/23/ | | | |
| | | t's leg. She | | | 4.4 The DON / designee w report audit findings to the | /ill | | |
| | | dressings to the | | | Continuous Quality Improver (CQI) Committee monthly fo | • | | |
| | | egs and applied | | | (6) months with the next med to be held 5/31/11. The CQI | eting | | |
| | lotion to th | e resident's feet. | | | Committee will monitor data presented for any trends, an | | | |
| | | ed her gloves | | | determine if further monitorir | | | |
| | and gathere | ed the supplies | | | necessary for compliance. 4.5 Systemic changes will | be | | |
| | and left the | resident's room, | | | completed by 6/1/11. | | | |
| | without wa | shing her hands. | | | | | | |
| | | | | | | | | |

| i | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214 | A. BUILDING | | nstruction 00 | (X3) DATE S COMPL 05/02/2 | ETED |
|---|---|--|--|--|--|---------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME | | | B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | 4/26/11 at #12 indicate have washed. A policy, tit Changes-We 8/09, provide Director of current, indifference global handsapp medication move glove hands" 4. Resident #180 4/27/11 at 11:25 hallway with Physical The PT #4 was walking and pulling her with the resident's care. | Nurses as licated cold dressings, eveswash bly s/dressingsre | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | AULTIPLE CO. | NSTRUCTION 00 | COMPI | | | |
|---|--|---|--|---------------|---|---|------------|--|
| 155214 | | A. BUILDING B. WING | | | 05/02/2011 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 1 | DDRESS, CITY, STATE, ZIP CODE | _ | | |
| ST ANTHONY HOME | | | 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | · | | | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR | | COMPLETION | |
| TAG | + | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | | ne catheter was being | | | | | | |
| | 1 ^ | and PT #4 adjusted the | | | | | | |
| | 1 | tubing by bringing the tubing forward under the | | | | | | |
| | 1 | nooking the catheter bag | | | | | | |
| | | 's walker. PTA #5 and PT | | | | | | |
| | | gloves or wash their | | | | | | |
| | | after adjusting the | | | | | | |
| | | The catheter tubing was | | | | | | |
| | laying on the flo | or and as the resident was | | | | | | |
| | ambulating the to | ubing was being dragged | | | | | | |
| | and kicked by th | e resident's feet. At 11:28 | | | | | | |
| | 1 ^ | dent stood up from her | | | | | | |
| | | PTA #5 and PT #4 went to | | | | | | |
| | | it touching the resident as | | | | | | |
| | 1 - | PTA #5 and PT #4 then | | | | | | |
| | | Resident #180 touching | | | | | | |
| | | resident's wheelchair, and | | | | | | |
| | walker. | | | | | | | |
| | During an interv | iew on 4/27/11 at 11:35 | | | | | | |
| | a.m., LPN #10 i | ndicated the therapy staff | | | | | | |
| | | n gloves and washed their | | | | | | |
| | hands after adjusting the catheter tubing. | | | | | | | |
| | She indicated the therapy staff should | | | | | | | |
| | wash their hands | between residents. | | | | | | |
| | A facility policy, | , titled "Hand-washing", | | | | | | |
| | dated 5/10, recei | ved from the DoN | | | | | | |
| | ` | ses) as current, indicated | | | | | | |
| | | g should be performed | | | | | | |
| | 1 - | ds are accidentally soiled, | | | | | | |
| | | val, and between resident | | | | | | |
| | contacts." | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/02/2011 | | | | | | | |
|---|--|---|---|---|--|--|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 1 | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | | |
| | and Replenishing 8/09, received fro indicated "Cov | g with a scoop in a clean | | | | | | | |